

FILED DEC 13 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **38863**
Registrar's No. **10375**BIRTH NO. **819R.3-54** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. JOHNS 4201	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LUKE'S HOSPITAL		d. STREET ADDRESS (If rural, give location) 8646 MORAN AVE.	

3. NAME OF DECEASED (Type or Print) a. (First) STEPHEN b. (Middle) JOSEPH c. (Last) HOMAN			4. DATE OF DEATH (Month) (Day) (Year) NOV 13, 1954		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH NOV. 13 1954		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS MO		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME JOSEPH S. HOMAN JR.		13b. MOTHER'S MAIDEN NAME JEAN MILDRED SCHUMPER		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NOT		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS JOSEPH S. HOMAN JR. ST. LOUIS MO.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diphtheritic toxin a year or more of lung, liver & spleen			INTERVAL BETWEEN ONSET AND DEATH
		ANTECEDENT CAUSES DUE TO (b) of lung, liver & spleen			
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 5614		

22. I hereby certify that I attended the deceased from **2:40 11-13, 1954**, to **3:30 am 1-1, 1954**, that I last saw the deceased alive on **2:40 am, 1954**, and that death occurred at **2:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Chas. O. Keefe M.D. (Degree or title)		23b. ADDRESS 3720 Washington		23c. DATE SIGNED 11-15-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE NOV. 15, 1954		24c. NAME OF CEMETERY OR CREMATORY ST. PETERS CATH. CEM.	
24d. LOCATION (City, town, or county) (State) ST. CHARLES MO		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. L. Prinster, St. Charles Mo.			
DATE REC'D BY LOCAL REG. NOV 15 1954		REGISTRAR'S SIGNATURE J. Carl Smith M.D.			

(Licensed Embalmer's Statement on Reverse Side)

PRINSTER-HUGHES FUNERAL HOME

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed

Body not embalmed
C. L. Penister Director

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.